

MidState Medical Center

DPH Corrective Action Plan

Approved
9/4/19
SHN

In response to DPH's Licensure Visit on 7/1/2019 through 7/3/2019.

Issue: On 7/1/2019 the CT Department of Public Health presented to Midstate Medical Center for an unannounced complaint investigation regarding a patient that had been inpatient at our facility from the dates of 5/16/19 thru 5/20/19. The patient had been brought to Midstate Medical Center from Whiting Forensic Hospital, a state facility, with the complaint of a foreign body. The patient is on a civil commitment at Whiting Forensic Hospital as he requires a higher level of observation than could be provided at the previous state hospital where he was inpatient. The patient is maintained on a 2:1 observation status at Whiting Forensic Hospital. The patient was brought by EMS, in handcuffs and in police custody with a psychiatric patient care attendant from Whiting Forensic Hospital. After removing the handcuffs the police officer and the psychiatric patient care attendant left the premises stating that they were directed to deliver the patient and then return to the facility. The patient's medical history includes bipolar affective disorder, depression, Pica in adults, PTSD and schizophrenia. The patient had continuous 2:1 observation (Security Officer and Tech/Sitter) while inpatient at Midstate Medical Center. The patient was examined in the ED and then brought to the OR for removal of a foreign object in his urethra. A 4cm portion of celery was removed from his bladder; he was then recovered and sent to an inpatient unit. Admission orders included continuous patient observation / sitter (one staff member and one security staff observing the patient), No items to be left in the room, no utensils, paper products only, visual attention at all times. While inpatient the patient was able to obtain a needle cap and inserted it into his urethra and subsequently was taken to the OR on 5/17/19 for removal of the needle cap. On 5/19/19, while still inpatient, the patient swallowed an AA battery which he obtained from the TV remote and subsequently was taken to the OR for removal of the battery. The patient was discharged back to Whiting Forensic Hospital on 5/20/19.

Additionally, one of three sampled patients (patient #10) reviewed for restraints, did not have documentation of assessment every two hours for a non-violent restraint, and did not have a physician order for discontinuation of the restraint. For one of three sampled patients (patient #1) there was no documentation that the patient was examined by a provider when a daily restraint order was renewed.

Corrective Actions with Completion Dates:

On 7/2/2019, while the DPH surveyor was still on premises during the investigation, a Corrective Action Plan was developed and implemented. An environmental risk assessment was performed with members of Nursing, Behavioral Health and Facilities, on all non-Behavioral Health units where a patient who has been found to be at risk for harm may be admitted. An Environmental Safety Room Preparation Form was developed which is unit specific. The purpose of the form is to assist staff in preparing a non-behavioral health, ligature risk room to be as safe as possible for the patient and as a guide to staff. The Nurse assigned to the patient, the sitter who is assigned to the patient and the Nurse Tech/s who will be attending to the patient gather and review the Safety Room Preparation form and sweep the room for any items that may be removed. There is a place on the form to acknowledge items that cannot be removed or secured because they are clinically indicated. These items will be reviewed by the Nurse, Sitter and Nurse Tech to ensure that the form is complete and everyone is aware of the remaining risks in the room. At this time the Nurse and sitter both sign the form and it is left with the sitter for reference. When there is a change of RN, a new form will be completed by the current RN, oncoming RN, the sitter and the tech/s. When there is a change of sitter the new sitter will review the current form with the RN or current sitter, ask any questions they may have and sign the form indicating they have been briefed and accept responsibility for the patient's safety and ligature risks in the room. There is a portion of the form that Public Safety will complete and sign on patient's admission to the room after they have performed a safety check on the patient and performed a safety check on the room (if indicated). The form also has a section that will be filled out whenever a visitor presents to visit the patient. The visitor will have a safety check by security and their personal items will be secured in a locker which has been placed on all inpatient units, the sitter will be in possession of the key and will give to visitor when they exit the room. Once a visitor exits the room the security check will need to be completed again before re-entry.

Staff education began on 7/2/19 with a group education which was given by the Regional Director of Behavioral Health Services, the Regional Manager of Behavioral Health Services and Nursing Education. Participants included the Director of Nursing, Regional Directors, Directors, Regional Managers, Clinical Nurse Managers, Clinical Resource Leaders (CRL's), Hospital Supervisors and Public Safety Leadership. After the education and being given an opportunity for questions and discussion the attendees signed a letter of attestation stating they had reviewed the Environmental Safety Room Preparation form, the Behavioral Care Plan for high risk patient's, understood the SBAR which was created for the Environmental Safety Room Preparation form and would contact management or education for further explanation if needed. These attendees were responsible to return to their respective areas and begin educating staff using the Train the Trainer model. In the event that a patient meeting the criteria for risk of harm was going to be admitted to a non-behavioral health unit, only staff that had this training and signed the attestation would be allowed to accept the patient and have interaction with the patient. A Healthstream assignment regarding "Care of the Self-Injurious/Suicidal Behavioral Health Patient in a Non-Behavioral Health Setting" was assigned to all RN's, Nurse Tech's and Sitters on July 11, 2019 with a completion date of Aug 10, 2019. As of August 29, 2019 we have a 99.87% completion rate. The Healthstream includes the process and standard work for the Environmental Safety Room Preparation form, Standard Work and an algorithm for determining Care of the Behavioral Health Patient in the Emergency Department. The process for Behavioral Health patients at risk of harm in non-Behavioral Health areas and related paperwork was discussed in person at Daily Lean huddles. All Nursing staff were required to sign an attestation stating that they had reviewed the Behavioral Care Plan for high risk patient's, reviewed the Environmental Safety Room Preparation form, understood the Environmental Safety Checklist SBAR and they will contact management or education staff for further explanation or instruction as needed. The Nursing Education Staff rounded repeatedly on all Non-Behavioral Health inpatient units and Emergency Department to reinforce education and facilitate discussions and address questions or concerns. Every incidence of a Behavioral Health patient at risk of harm who is admitted to a Non-Behavioral Health Unit is audited by the Director of Nursing or leadership designee and any non-compliance is addressed as close to real time as possible.

In the event of a future need for Public Safety to observe a patient at risk of harm in a Non-Behavioral Health area, the Public Safety Officers have been re-educated in person by the Regional Manager of Public Safety as to the role and expectations when assigned to observe a patient at risk for harm in a Non-Behavioral Health area. All oncoming Public Safety Officers attend a change of shift report facilitated by the Public Safety Supervisor at which time any safety concerns in the hospital including this patient population/ patients at risk of harm, are discussed. Opportunity is given for discussion and questions. A mandatory Restraint and Constant Observation for non-nursing e-learning module and demonstration of appropriate application and removal of restraints is completed at hire and annually for Public Safety.

For sustained compliance: Annual Mandatory Education will include Care of the Behavioral Health Patient at risk of harm in a Non-Behavioral Health area for all inpatient and ED nursing staff.

Restraint and Constant Observation education is mandatory on hire for Nurses, Techs, and Public Safety. Annual Mandatory Education will include Care of the Behavioral Health Patient at risk of harm in a Non-Behavioral Health area for all inpatient and ED nursing staff.

Nurse Techs complete an annual competency on Constant Observation.

Nurse Techs completed a competency demonstration and live class around constant observation with skill validation on application and removal of restraints including documentation in June 2019.

Public Safety completes an annual competency on constant observation; the 2019 competency is in progress to be completed September 30th.

The Zero Suicide EOC sub-group performs quarterly ligature risk assessments for Behavioral Health units and annually for non-Behavioral Health inpatient units and the Emergency Department. These assessments are reported up to the EOC Committee. Team members include Behavioral Health, Facilities, Nursing and Quality staff. Any areas of concern are addressed in real time.

Rounding will occur on staff assigned to observe patient to ensure that they are alert and observant.

Of note, due to the unique behaviors (Pt. #1) exhibits, a Care Plan has been developed for Patient #1 in the event that he presents to Midstate Medical Center. The plan is focused on his safety and includes immediately placing the patient on a constant 1:1 observation status, in addition a Public Safety Officer will be assigned to observe patient at all times. This plan is specific regarding his diet order, allowed items and how they are to be monitored and additional observation requirements.

The Acute Behavioral Unit (ABU) is where the omission of q 2hour restraint documentation occurred and there was no provider assessment on one day of the patient being in non-behavioral restraints. This area is a locked Behavioral Health Unit within the Emergency Department. It is staffed and overseen by Behavioral Health Management. Upon discovery of the omission the Behavioral Health Manager and Clinical Resource Lead (CRL) sent out an SBAR to all ABU Nursing staff regarding Non-Violent Restraint Documentation every two hours with emphasis on restraint orders, daily provider assessment, provider progress note and assessment. The Restraint and Seclusion Policy was attached to the SBAR for review. A read receipt was requested and as of 8/7/19 there is 100% completion. The SBAR was posted on the unit and discussed with staff during daily leadership rounding and at bi-weekly Lean huddles. The staff member involved in the omission was coached and mentored and all ABU staff are being re-educated as a learning opportunity. All restraint episodes in the ABU are being audited by the CRL's as close to real time as possible. Any non-compliance is addressed at time of discovery by the CRL and an email with documentation of coaching is sent to the Manager of Behavioral Health.

For sustained compliance: Nurse Techs completed a competency demonstration and live class around constant observation with skill validation on application and removal of restraints including documentation in June 2019. Nurses completed a competency demonstration and live class with skill validation on application and removal of restraints. The class included restraints, restraint alternatives, appropriate use of restraints, documentation, and roles and responsibilities during Feb-May 2019. Restraint and Constant Observation education is mandatory on hire for Nurses, Techs, and Public Safety.

Monitoring Plan:

The Director of Nursing or leadership designee will continue to audit every episode of a Behavioral Health patient at risk of harm on a Non-Behavioral Health Unit and address any non-compliance upon discovery until a compliance rate of 90% or better is achieved for a period of 3 consecutive months.

The CRL's in the ABU will *continue* auditing all restraint episodes that occur, addressing non-compliance as close to real time as possible and sending documentation of staff coaching to the Manager of Behavioral Health Services.

Responsible Person:

The Regional Vice President of Patient Care Services and the Director of Inpatient Medicine and Critical Care Services will be responsible for implementing the plan of correction which was approved by the surveyor prior to the visit.

DATE(S) OF VISIT: July 1, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Nursing Service (1) and/or (i) General (6).

1. *Based on observation, clinical record review, review of hospital policy, review of hospital documentation and staff interviews for 1 of 2 sampled patients (Patient #1) reviewed for self-harm behaviors (inserted foreign body in urethra and swallowed a battery), the facility failed to ensure the patient was supervised and/or continuous observation was maintained and/or failed to ensure the environment was free of hazards. The findings include:
 - a. Patient #1's diagnoses included schizophrenia, bipolar disorder, PICA (eating disorder) and self-mutilating behaviors.

Patient # 1 was admitted to the hospital on 5/16/19 for complaints of pain in the urethra after inserting a food item into the urethra. The History and Physical (H&P) dated 5/16/19 at 2:34 PM identified the patient stated that "he/she stuck a pen cartridge in his/her urethra." The H&P further identified the patient was placed with a one to one sitter and would be evaluated by urology. Review of the surgical report dated 5/16/19 identified the patient underwent a cystoscopic transurethral retrieval of celery.
 - i. Physician orders dated 5/16/19 at 3:22 PM directed continuous observation/sitter (one staff member and one security staff observing the patient). Physician orders dated 5/16/19 at 4:28 PM directed no items to be left in room, no utensils, paper products only, visual attention at all times.

Review of the patient treatment plan dated 5/16/19 identified a history of self-mutilating behaviors of inserting/ingesting foreign objects. Interventions included one to one and security present at all times, remove all objects from room, remote control to be with staff or outside of room, hands remain above blankets, and visualize patient while in bathroom.

Review of Patient safety checks dated 5/17/19 at 7:00 AM identified Patient # 1 reported he/she inserted a needle cap into his/her urethra at 9:00 PM while in the bathroom.

A physician progress note dated 5/17/19 at 1:40 PM identified that overnight, despite being on a one to one with security present, the patient inserted a needle cap into the urethra. The patient went to the Operating Room (OR) on 5/16/19 for foreign body removal and the patient went back to the OR for a second cystoscopy on 5/17/19 for removal of the needle cap. The note further identified there was significant swelling of the urethra, a Foley was placed and the patient was started on antibiotic therapy. Additionally, the patient would continue on one to one with security present and hand mitts would be added related to the patient's self-harming behaviors.

A physician order dated 5/17/19 directed to apply bilateral hand mitts.

Nurse's notes dated 5/17/19 at 3:53 PM identified mitts were placed on bilateral hands for safety due to unsuccessful education regarding patient's impulse to harm self, continue with two to one observation.

Interview with the Nurse Manager on 7/1/19 at 10:00 AM stated that when she was

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made aware of why the patient was being admitted on 5/16/19 she immediately implemented interventions to keep the patient safe (one to one plus security, remote control to be kept out of the patient's room, no small objects in room). The Nurse Manager stated that the patient was placed on a one to one plus a security person, items removed from the patient's room and when the patient was admitted to the unit all staff that were on at that time were educated, and staff after that were educated from the nurses.

Interview with MD # 1 on 7/1/19 at 2:25 PM stated that she went to see the patient on 5/17/19 after the nurse reported the patient was having pain and the patient reported that he/she inserted a needle cap into the urethra that was left behind from the nurse. MD # 1 stated that the patient reported to her that he/she inserted it the evening before but was not specific on the time.

Interview with Nurse Tech # 1 on 7/2/19 at 8:30 AM stated that on 5/17/19 at the change of shift the patient reported to the oncoming nurse that the evening before (5/16/19) around 9:00 or 10:00 PM he/she inserted a needle cap into the urethra.

Interview with Nurse Tech # 2 on 7/2/19 at 8:47 AM stated that on 5/17/19 the patient told the incoming day nurse that he/she inserted a needle cap into the urethra while in the bathroom. Nurse Tech # 2 stated that during his sit time (observing the patient), the patient remained in bed and did not use the bathroom.

Interview with Security Officer # 1 on 7/2/19 at 9:00 AM stated that when he was observing the patient (5/17/19 nights), the patient's hands were on top of the blankets. Security Officer # 1 stated that he was told by his supervisor to be facing the patient and constantly looking at the face and hands. Security Officer #1 stated that he was not present when the patient told staff he/she inserted a needle cap into the urethra but did hear the patient complain of pain. Security Officer #1 stated that he did observe some of the staff watching the patient and the television.

Interview with RN #1 on 7/2/19 at 2:00 PM stated that she went to see the patient on 5/17/19 (day shift) and was told by the patient that he/she "did it again". RN # 1 stated that she was told by the patient that he/she inserted a needle cap into the urethra the previous night around 9:00 PM. RN # 1 stated she notified the MD and the patient was sent to the OR to have the cap removed. RN # 1 further stated that the patient's room was cleaned and checked for any small objects and when the patient came back onto the unit mitts were placed on the patient's hands and staff was re-educated.

Interview with RN # 2 on 7/2/19 at 2:20 PM stated that during her shift (7:00 PM- 5/16/19 to 7:00 AM- 5/17/19) the patient complained of pain while urinating and she medicated the patient for pain. RN # 2 stated that she did not assess the patient's genital area when he/she complained of pain.

Interview with Nursing Tech # 3 on 7/2/19 at 2:35 PM stated that she was doing the one to one when the patient came from the Post Anesthesia Care Unit (PACU) on 5/16/19. Nursing Tech # 3 stated that she took the patient to the bathroom and he/she complained of pain when urinating. Nursing Tech # 3 stated she stood in the

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doorway and was going back and forth looking at the patient and around the room. Nursing Tech # 3 stated that at no time did she see the patient touching the genital area.

The hospital failed to ensure that a patient was adequately supervised by staff members resulting in the patient obtaining a needle cap and inserting it into the urethra which required a medical procedure to remove the cap.

- ii. Review of Patient #1's treatment plan dated 5/17/19 identified the plan was updated to include bilateral hand mitts.

Review of the patient safety checks documentation dated 5/19/19 at 12:45 PM identified the patient "ate a battery."

Physician progress notes dated 5/19/19 at 1:13 PM identified the patient complained of burning in the chest and had swallowed a battery in the morning. The note identified the patient was able to get his/her fingers out of the mitt and remove the battery from the television remote control and put it into his/her mouth. The note further identified the patient was to have an endoscopy to remove the battery and was now to have the hand mitts tied to prevent the patient from ingesting foreign objects.

Nurse's notes dated 5/19/19 at 6:54 PM identified that the patient remained on one to one supervision with security staff present. Patient #1 reported that he/she was able to remove 2 fingers from the hand mitt, remove the AA battery from the remote control and ingested the battery. The note identified the patient reported a burning sensation in the stomach, the physician was made aware and ordered a STAT X-ray which noted a battery in the patient's stomach. Review of the operative report dated 5/19/19 identified the patient underwent an endoscopy for the removal of a AA battery from the patient's stomach. The note further identified that the patient's hand mitts were now to be tied, and every 2 hour room checks were to be conducted. Review of the treatment plan dated 5/19/19 identified the treatment plan was updated to include tied bilateral hand mitts and room checks.

Interview with the Nurse Manager on 7/1/19 at 10:00 AM stated that the patient's treatment plan was updated after the patient ingested a battery to include tied bilateral hand mitts and room/bed checks every two hours.

Interview with MD # 1 on 7/1/19 at 2:25 PM stated that on 5/19/19 she went to see the patient after the patient complained of stomach burning and the patient told her that when the security staff put the remote down when security was changing staff, he/she removed the battery and then swallowed it. MD # 1 further stated that she spoke with nursing staff related to the two to one (one staff and one security) not working. MD # 1 stated that she had walked into the room at different times and observed the staff watching television and not watching the patient.

Interview with the Regional Manager of Security on 7/2/19 at 10:15 AM stated that he met with the nursing manager regarding the safety of the patient and educated his security staff regarding doing the sit (observation) on Patient # 1. The Regional Manager stated that after the second incident he came in again and re-educated the

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staff again on the sit and the new interventions the nursing staff implemented including tied hand mitts and every two hour room checks.

Interview with RN # 3 on 7/2/19 at 2:50 PM stated that she was called to the patient's room on 5/19/19 and the patient told her that he/she was able to remove 2 fingers out of the mitt and take the battery from the remote control, "fake coughed" and swallow a AA battery. RN # 3 stated that she could not recall if she asked the patient how or when he/she did it.

Interview with Security Officer # 2 on 7/2/19 at 2:30 PM stated that he was sitting with the patient on 5/19/19 when the patient reported he/she swallowed a battery. Security officer # 2 stated that he was not sure where the remote was and that he was not responsible for it.

Interview with the Nurse Manager on 7/1/19 at 10:00 AM stated that the remote control to the television was to be kept outside of the patients room and that staff were educated on this when the patient was admitted.

The hospital's Observation of Patients policy identified that one to one observation is direct observation of a patient by a staff member.

The hospital failed to ensure that a patient was adequately supervised by staff members resulting in the patient obtaining an AA battery and ingest the battery, which required a medical procedure to remove the battery.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (e) Nursing Service (1) and/or (i) General (6).

2. Based on clinical record review, hospital policy and staff interview for 1 of 3 sampled patients reviewed for restraints, (Patient # 10) the facility failed to assess and document the use of a restraint every two hours according to hospital policy. The findings include:
 - a. Patient # 10 was admitted to the hospital on 6/24/19 for self-injurious behaviors. Diagnoses included Schizophrenia.

Physician orders dated 6/24/19 at 11:36 AM directed the use of bilateral soft hand mitts, tied (in accordance with the hospital policy for the non-violent non-self destructive patient). Review of the restraint assessment flowsheets dated 6/24/19 during the period of 11:36 AM through 3:45 PM failed to identify the patient was assessed every two hours, and failed to identify a physician order was written for the discontinuation of the tied bilateral hands mitts in accordance with hospital policy.

Interview with Quality and Regulatory staff on 7/3/19 at 11:00 AM and review of the clinical record identified that Patient #10's restraint assessment flowsheet dated 6/24/19 failed to identify that the patient was reassessed for the use of the restraints every two hours as the restraint policy indicated. Quality and regulatory staff stated that it is the hospital policy to assess the patient's behaviors every two hours to ensure the restraints are needed. Review of the Restraint and Seclusion policy identified that patients using non-violent or non-self-destructive restraints are to be assessed every two hours. The assessment is to include the application of the restraint, signs of injury, physical and psychological status,

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patient care needs, range of motion, and need for least restrictive and/or discontinuation of restraints.

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3. Based on clinical record review, hospital documentation and policy review, for 1 of 3 sampled patients reviewed for restraints (Patient # 1) the facility failed to ensure that the patient was examined by a provider when a daily restraint order was renewed. The findings include:

- a. Patient # 1 was admitted to the hospital 5/16/19 after inserting a foreign object into the urethra.

Review of the clinical record identified the patient was placed in tied bilateral hand mitts on 5/19/19 at 1:00 PM until 5/20/19 at 1:30 PM.

Review of physician orders dated 5/19/19 at 1:04 PM directed to apply non-violent or non-self-destructive padded mitts, tied.

Physician orders dated 5/20/19 at 9:03 AM directed to apply tied bilateral hand mitts.

Review of clinical record with Quality and Regulatory staff on 7/3/19 at 11:00 AM failed to identify that the physician examined the patient on 5/20/19.

Review of facility policy for restraint and seclusion identified for non-violent or non-self-destructive restraints, the provider must examine the patient daily and enter a new order if restraints are to be continued.

